STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195493	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kinder Retirement and Rehabilitation Center	13938 Hwy 165 Kinder, LA 70648

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 38894 Based on Interview and Record Review, the facility failed to ensure licensed nurses had the appropriate competencies and skill sets to provide nursing services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by the failure to ensure two transcribed verbal narcotic medication orders included the strength of the drug, failure to ensure two written narcotic orders were correctly entered into the electronic medical record, failure to ensure electronic narcotic medication orders included valid dosing instructions, failure to ensure dosing of narcotic medication on narcotic sign-out log matched dosing information on Medication Administration Record, and by failing to ensure all narcotic medication doses signed out on Narcotic Medication Record were documented as given on Medication Administration Record for 1 (#2) of 14 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14) sampled residents. Findings: Review of handwritten Physician Orders dated 09/25/2024 revealed an order for Morphine 100mg/5mL, Give 0.25mL SL/PO Q2H as needed pain or shortness of breath (SOB). Review of MAR for 10/01/2024 through 10/08/2024 included Morphine Sulfate Oral Solution 20mg/5mL Give 0.25mL by mouth every 2 hours as needed for pain; SOB related to Pain - GIVE 0.25ML PO Q2HR PRN PAIN/SOB with start date of 10/01/2024 . Unable to find this order during review of electronic and paper records. Review of verbal orders written by S2 LPN on 10/08/2024 revealed the following: 1mL Morphine PO now one time dose Dx: air hunger Increase Morphine to 0.5mL Q2H PO PRN for air hunger No concentration noted on either order. Review of facility policy entitled Orders - Medication stated orders for medications must include name and strength of drug, quantity of specific duration of therapy, dosage and frequency of administration, route of administration if other than oral, and reason for which given. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MAR for 10/08/2024 included Morphine Sulfate oral solution 100mg/5mL give 1mL by mouth one time only for air hunger/SOB, although this concentration was not included on the written order. Review of MAR for 10/08/2024 through 10/09/2024 included Morphine Sulfate oral solution 20mg/5mL give 0.5mg by mouth every 2 hours as needed for pain, SOB related to pain - GIVE 0.25ML PO Q 2 HR PRN PAIN/SOB, although this concentration was not included on the written order. Order was inconsistent/ambiguous as 0.25mL does NOT provide 0.5mg. Additionally, order was written for 0.5mL, but entered electronically as 0.5mg. Interview on 12/17/2024 at 2:40 p.m., S1 DON confirmed she was unable to locate an order changing dose of Morphine Sulfate on 10/01/2024. S1 DON stated the information was entered incorrectly when the facility changed to PCC (Point Click Care) from their previous electronic health record on 10/01/2024. S1 DON asked if the two different orders provided the same dose of medication- advised her they did not. S1 DON stated she wanted to review what was given by reviewing the paper they write on rather than the copy of the MAR provided by the facility. Informed S1 DON two verbal narcotic orders written on 10/08/2024 did not include dose/concentration of medication. S1 DON viewed orders and confirmed the orders did not include dose/concentration and should have. Advised S1 DON the order to increase oral PRN narcotic on 10/08/2024 indicated mL, but when entered electronically was entered as mg. Additionally, informed S1 DON the same order stated to give 0.5mg and 0.25mL, which were not the same dose. S1 DON viewed copy of order and stated she would follow up regarding these issues. Interview on 12/17/2024 at 2:55 p.m., S1 DON brought Morphine Sulfate box, which she stated was from locked narcotic box, labeled with resident name and initial concentration/order. S1 DON stated Resident #2 had received the 100mg/5mL concentration from 09/25/2024 through 10/09/2024. S1 DON also provided copy of narcotic medication records (narcotic sign-out sheets) for Resident #2 with Morphine 100mg/5mL dosing indicated. S1 DON confirmed both Morphine orders dated 10/08/2024 were incomplete and should have contained dose/concentration. S1 DON confirmed the order to increase Morphine dated 10/08/2024 included MG but was entered into PCC as ML and should not have been. S1 DON stated the order was transcribed incorrectly. During an interview on 12/17/2024 at 3:00 p.m., S2 LPN confirmed the Morphine dose on the narcotic medication record (sign-out sheet) did not match the Morphine dose on the MAR and should have. S2 LPN confirmed she had signed out and administered Morphine on multiple occasions, despite this inconsistency. S2 LPN confirmed she should have ensured the dosing matched. S2 LPN reviewed Morphine orders written on 10/08/2024. S2 LPN confirmed she wrote verbal orders for morphine on 10/08/2024. S2 LPN confirmed both orders did not include dose/concentration and should have. Orders - Medication policy reviewed with S2 LPN. S2 LPN confirmed she did not follow the policy when she wrote the orders and should have.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082 Based on record review and interview, the facility failed to ensure responsible party notification was documented in the medical record of a resident who was tranferred to the hospital for 1 (#12) of 14 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) sampled residents. The total facility census was 75 residents. Findings: Review of the facility's undated policy titled Change in a Resident's Condition Status read in part . Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. Procedure: 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when: E. It is necessary to transfer the resident to a hospital/treatment center. If unable to contact RP, the charge nurse shall document changes on the resident's medical record 6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of Resident #12's Medical Record revealed an admitted [DATE] with diagnoses that included Peripheral Vascular Disease; End Stage Renal Disease; Chronic Venous Hypertension with Ulcer of right lower extremity; Anxiety disorder; Chronic Obstructive Pulmonary disease; Pressure Ulcer of Sacral Region stage 4; Pressure Ulcer of Right heel Unstageable; Acute Embolism and Thrombosis of left femoral vein; Osteomyelitis; Hypotension; Obesity; Type 2 Diabetes Mellitus; Edema; Hypertensive Heart Disease with Heart Failure; Review of Resident #12's Significant Change MDS revealed a BIMS score of 13 which indicated the resident was cognitively intact. Resident #12 required extensive assistance with bed mobility, transfers, and toilet use. Supervision required for eating. Resident had shortness of breath or trouble breathing when lying flat. Review of Resident #12's Care Plan with a Target date of [DATE] revealed the resident has shortness of breath. Interventions included, Resident sent to emergency room (ER) to evaluate (eval) and treat for Hypoxia (initiated [DATE]). The resident has asthma. Interventions included: Give nebulizer treatments and oxygen therapy as ordered; Monitor vital signs, skin color, pulse oximetry, airway functioning, and degree of restlessness which may indicate hypoxia (initiated [DATE]); Position resident in Fowlers to facilitate breathing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's Physician Orders revealed in part .Oxygen (o2) at 4L/MIN (Liters per minute) via nasal cannula continuously every shift related to wheezing with a start date of [DATE]. Review of Resident #12's Discharge Summary dated [DATE] revealed resident discharged to hospital. discharge date : [DATE]. Summary of treatment: skilled services provided upon admission. Discharge condition: expired at hospital. Review of the resident #12's Nurse Progress Notes for [DATE] revealed the following: [DATE] at 1:30 p.m.-Resident sent to ER to eval and treat for Hypoxia [DATE] at 9:56 a.m.-AT hospital [DATE] at 9:45 a.m.-continues to be at hospital [DATE] at 10:00 p.m.-Daughter, RP; came to facility and stated, daddy just gained his wings. [DATE] at 12:26 p.m.-Resident expired at hospital Review of Resident #12's Nurses Notes revealed no documentation for notification of Resident #12's transfer to the hospital on [DATE] to Resident #12's RP. In a telephone interview on [DATE] at 12:26 p.m. with resident's RP stated the facility did not notify her that resident #12 was sent out to the hospital on [DATE]. She stated the resident called her on [DATE] from the hospital and informed her he had been admitted to the hospital. In an interview on [DATE] at 12:48 p.m. with S1 DON confirmed no documentation in Resident #12's medical record notifying resident #12's responsible party that he was transferred to the hospital on [DATE] and there should have been. In an interview on [DATE] at 12:50 p.m. with S3 LPN stated she was resident #12's nurse on [DATE]. S3 LPN stated the resident began having some respiratory difficulty suddenly after drinking water, vital signs were obtained, and his oxygen sat was low despite being on oxygen. Resident #12 was then transferred to hospital on [DATE]. S3 LPN stated she didn't document notifying the RP when the resident was transferred to the hospital on [DATE] and should have.